TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNIVERSITY MEDICAL CENTER

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-16-1754-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier processed and paid $155348.42 on this 22 day inpatient stay. . . . This should pay at the DRG rat e of $123834.33 x 143% = 177083.09. . . . We did not ask that the implant be paid separate so they should be included in the DRG rate at 143%."

Amount in Dispute: $21,734.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DRG 003 was priced @ 143% of CMS IPPS allowable rate pf $108,635.26, pr $155,34842. the discharges status for this bill is "62" and affects the CMS IPPS allowable rate. It appears the facility submitted the CMS pricer without entry as a transfer 62 – Discharged/transferred to an inpatient rehabilitation facility."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2015 to June 26, 2015	Inpatient Hospital Services	$21,734.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

- P300 – CHARGE EXCEEDS FEE SCHEDULE MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
- B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

   The amount of the payment is the sole issue in contention. The requestor asserts that they should have been paid the amount of the DRG payment multiplied by 143%. The respondent points out that the medical bill and records indicate a postacute-care transfer to a rehabilitation facility (status code 62 in field 17 on the medical bill) which requires payment according to a different formula.

   Per 28 Texas Administrative Code §134.404(d), for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule.

   Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 3, §40.2.4 C - **Postacute Care Transfers**, if the patient is subsequently transferred from the hospital where the patient was admitted to an inpatient rehabilitation facility (Patient Status Code 62), the admission qualifies for payment under an alternative methodology; the patient's discharge is assigned, as described in 42 CFR 412.4(f)(2), (f)(5) and (f)(6), to one of the qualifying Special Pay MS-DRGs referenced in Table 5 of the final IPPS rule for the applicable fiscal year. For such cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

   In the IPPS pricer software, you simply indicate "Y" for the "POST-ACUTE XFER" entry field, and it will make the appropriate adjustments to the payment calculation.

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 003. The services were provided at University Medical Center in Lubbock, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $108,633.73. This amount multiplied by 143% results in a MAR of $155,346.23.

3. The total recommended payment for the services in dispute is $155,346.23. The insurance carrier has paid $155,348.42. The amount due to the requestor is $0.00. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.